ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

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Password: 12345

For attendance, purposes please text the following code: LARVAZ to 608-260-7097

Session Date: Friday, December 15, 2023

Didactic Topic and Presenter:
Coordination of Care for Patients Coming In/Out of Carceral Settings

Elizabeth Salisbury-Afshar, MD, MPH
Program Director, Preventive Medicine Residency
Medical Director of Harm Reduction Services, Wisconsin Department of Health Services
Associate Professor, Departments of Family Medicine and Community Health and Population Health Sciences
University of Wisconsin School of Medicine and Public Health

- 12:15 PM: Attendance text-in – Introductions
- 12:25 PM: Case Presentation
  - Presenter: Ana Pearson, MD - *Addiction Medicine Fellow, Dept. of Family Medicine and Community Health, University of Wisconsin—Madison*
- 1 PM: Didactic Presentation and Discussion
  - Presenter: Elizabeth Salisbury-Afshar, MD, MPH
- 1:15 PM End of Session

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Interprofessional Continuing Education Partnership | University of Wisconsin–Madison | School of Medicine and Public Health | School of Nursing | School of Pharmacy

Wisconsin Department of Health Services

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This session is designed to meet the requirements outlined in the Medication Access and Training Expansion (MATE) Act. (Click here for more information.) Number of hours: 1

ECHO ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics
2022-2024
Coordination of Care for Patients Coming In/Out of Carceral Settings
12/15/23
Didactic Presenter: Elizabeth Salisbury-Afshar, MD, MPH
Case Presenter: Ana Pearson, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:

Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Pharmacy Technicians, Psychologists, Social Workers, Patient/Caregivers, Students

Objectives:

As a result of this educational regularly scheduled series, learners as members of the healthcare team will be able to:

- Discuss with patients about legal involvement in standardized and non-stigmatizing way
- Describe federal expectations related to substance withdrawal and substance use disorder treatment in jails and prisons
- Develop plans for patients for anticipated jail/prison time and/or to support transition back to the community

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Name	Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?	COI completion date
Randall Brown	RSS Chair	Usona Institute (Grant / Contract), multi-disciplinary association for psychedelic studies (Grant / Contract)	Yes	1/30/2023
Nada Rashid	RSS Coordinator	No relevant financial relationships to disclose	No	1/31/2023
Kathleen Maher	RSS Coordinator	No relevant financial relationships to disclose	No	1/30/2023
Ritu Bhatnagar	Planner	No relevant financial relationships to disclose	Yes	1/29/2023
Paul Hutson	Planner	No relevant financial relationships to disclose	Yes	1/28/2023
Susan Mindock	Planner	No relevant financial relationships to disclose	No	1/31/2023
Sheila Weix	Planner	No relevant financial relationships to disclose	No	2/3/2023
Kellene Eagen	Planner	No relevant financial relationships to disclose	No	1/27/2023
Joseph Galey	Planner	No relevant financial relationships to disclose	Yes	1/27/2023
David Leinweber	Planner	No relevant financial relationships to disclose	No	4/13/2023
Elizabeth Salisbury-Afshar	Presenter	No relevant financial relationships to disclose	No	11/16/2023

Ana Pearson	Presenter	No relevant financial relationships to disclose	No	12/1/2023

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Case Presentation

Ana Pearson, MD
Elizabeth Salisbury-Afshar, MD, MPH
University of Wisconsin–Madison

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Case Introduction

- middle-aged female with sickle cell disease, OUD, cocaine use disorder, housing insecurity currently admitted with sickle cell pain crisis, complicated by acute opioid withdrawal
  - Frequent admissions with similar presentation
  - Significant barriers to accessing outpatient care

- How can we help this patient with extremely high opioid tolerance, housing insecurity and social instability and a desire to initiate methadone better access treatment for SUD outside the hospital?

Medical & Behavioral Health Diagnosis:	Current Medications:

• Sickle cell disease
    • Prescribed high dose opioids since childhood
    • complicated by frequent hospitalizations for pain crises (~12 admissions in past year)
• Opioid use disorder, severe
• Cocaine use disorder
• Depression
• PTSD/trauma
• Anxiety
	• No current MOUD
	• Not currently prescribed outpatient opioids for sickle cell pain due to active OUD and lack of follow up
	• During admissions:
	    • hydromorphone PCA for sickle cell pain and for acute opioid withdrawal
	    • MME during admissions >1000

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Substance Use

- History:
  - Chronic prescription opioids since childhood
  - Daily injection heroin and crack cocaine use for many years
  - Many previous overdoses (including one during hospital admission)
  - Consistently reports withdrawal symptoms during admission while on high-dose hydromorphone PCA
- Past treatments:
  - Previously treated with methadone, difficulty titrating due to inconsistent follow up and slow outpatient titration protocols
  - Previously treated with buprenorphine-naloxone through PCP and hematology clinic, discontinued due to lack of follow up and insufficient pain management
  - Past residential, IOP several times

Social History:	Family History:
• Significant social instability • Stays with various friends and family members across town • No consistent address to schedule medical transportation in advance • Unemployed • Experienced significant trauma in childhood	• Parents, siblings, extended relatives with h/o OUD

"Of note, during my interview, she noted that she feels like she is always being set up for failure- noting that she really wants methadone pills to be prescribed as an outpatient. She cites challenges with getting to the OTP daily b/c of lack of housing and inability to schedule transportation b/c she doesn't know where she'll be staying from one day to the next. We discussed residential treatment but she's not sure that would work either- voices concerns about going there when not on a high enough methadone dose and having to leave to use and knows she will then be kicked out/not able to stay there. Feels there are no good options for her and voices frustration with the medical system - acknowledging that opioids were started by doctors at such a young age and led her down this path.

Voices feeling hopeless and cried throughout the discussion. She says her goal is to be well enough to spend more time with her daughter and to work at her nonprofit which she wants to focus on helping people with SCD"

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Patient strengths & protective factors:	Risk factors:
• Continues to expresses desire to engage in care • Is a parent, wants to be present for her child • Interest in starting a non-profit for patients with SCD • Medical teams willing to advocate for her	• Minimal social support or stability • History of many overdoses, high risk-use pattern, high opioid tolerance • Minimal recent outpatient follow up • Lack of trust and hope in medical system and social services • Significant medical and psychiatric co-morbidities

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Patient Goals & Motivations for Treatment

- Methadone tabs from primary care (not an option)
  - Restart methadone, ideally a rapid titration
- Pain control for acute sickle cell pain
- Wanted to pursue residential treatment
  - Only if confident withdrawal and pain would be adequately managed

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Proposed Treatment Plan

- Continue hydromorphone PCA for sickle cell pain
- Start methadone
  - rapid titration to achieve adequate craving control by time of discharge
- Referral to residential treatment
- Address transportation barrier

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Treatment Plan

- Methadone induction:
  - Day 1: 40 mg
  - Day 2: 50 mg
  - Day 3: 60 mg
  - Day 4: 70 mg
  - Day 5: 80 mg
- Daily tally of MME, very close monitoring and close coordination with OTP
- Weaned IV hydromorphone as tolerated, transition to orals
- No symptoms of sedation/respiratory depression

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Treatment Plan

- Transportation Coordination
  - Escalated case through her MA plan to the Veyo director
  - Engaged her insurance case manager, explained the situation, encouraged them to look at cost of repeat hospitalizations
- Outcome:
  - They agreed to allow her to call to schedule daily transportation and go outside the existing system

Treatment Plan

- Patient scheduled for intake visit at OTP on day of discharge
  - Discharged directly from hospital to OTP for intake and dosing
- She was accepted to a residential treatment facility and was admitted about 2 weeks later
- She was referred to Comprehensive Community Services (for case management services)
- She continued to attend OTP daily while in residential treatment, titrated methadone to 100 mg

Discussion:

- Listened to patient about her specific challenges and goals
- Work to address housing instability, transportation challenges
- Addressed her concerns about inadequate withdrawal management
- This type of coordination took significant time and effort

Coordination of Care for Patients Coming In/Out of Carceral Settings

Elizabeth Salisbury-Afshar, MD, MPH

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Learning Objectives

- Ask patients about legal involvement in standardized and non-stigmatizing way
- Describe federal expectations related to substance withdrawal and substance use disorder treatment in jails and prisons
- Work with patients to plan for anticipated jail/prison time and/or to support transition back to the community

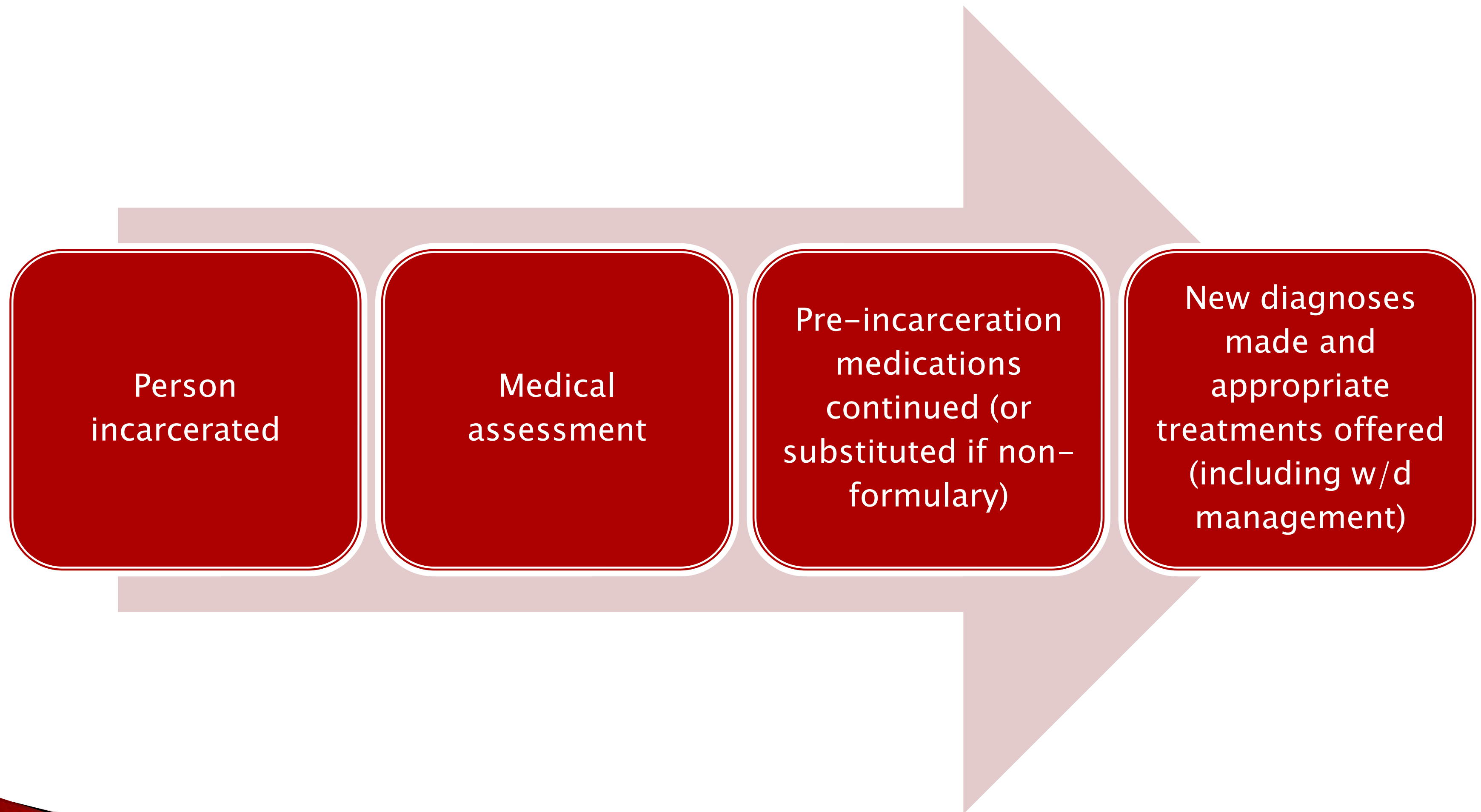
Agenda

- Terminology Check-In
- What should happen in Jails and Prisons
- How to support patients:
  - Screening for legal involvement
  - Planning for jail/prison time

Terminology

- Criminal legal vs. criminal justice
- Carceral vs. correctional
- Jail= run by the county
  - People can be in jail prior to being charged or for shorter sentences (typically <1 year)
- Prison= run by the state or feds
  - People are sent to prison AFTER being charged and typically for longer sentences (typically >1 year)

What Should Happen During Incarceration



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3) Does the ADA protect individuals who are taking legally prescribed medication to treat their opioid use disorder?

Yes, if the individual is not engaged in the illegal use of drugs. Under the ADA, an individual's use of prescribed medication, such as that used to treat OUD, is not an "illegal use of drugs" if the individual uses the medication under the supervision of a licensed health care professional, including primary care or other non-specialty providers.[10] This includes medications for opioid use disorder (MOUD) or medication assisted treatment (MAT). MOUD is the use of one of three medications (methadone, buprenorphine, or naltrexone) approved by the Food and Drug Administration (FDA) for treatment of OUD;[11] MAT refers to treatment of OUD and certain other substance use disorders by combining counseling and behavioral therapies with the use of FDA-approved medications.[12]

Example A

A skilled nursing facility refuses to admit a patient with OUD because the patient takes doctor-prescribed MOUD, and the facility prohibits any of its patients from taking MOUD. The facility's exclusion of patients based on their OUD would violate the ADA.

Example B

A jail does not allow incoming inmates to continue taking MOUD prescribed before their detention. The jail's blanket policy prohibiting the use of MOUD would violate the ADA.

facilities; homeless shelters; and schools, colleges, and universities.

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U.S. Department of Justice, Civil Rights Division, Disability Rights Section
Technical Assistance document: The Opioid Crisis and the ADA

1. Establish w/d management policy to comport with legal, regulatory and clinical standards
2. Create w/d management protocols and maintain fidelity
3. Ensure proper staffing and resources are in place to implement policies and protocols
4. Train staff to ensure their understanding of and readiness to implement policy and protocol
5. Engage in continuous QI

BUREAU OF JUSTICE ASSISTANCE

MANAGING SUBSTANCE WITHDRAWAL IN JAILS: A LEGAL BRIEF

A disproportionate number of people in jails have substance use disorders (SUDs).[1] Incarceration provides a valuable opportunity for identifying SUD and addressing withdrawal.[*] Within the first few hours and days of detainment, individuals who have suddenly stopped using alcohol, opioids, or other drugs may experience withdrawal symptoms, particularly when they have used the substances heavily or long-term. Without its identification and timely subsequent medical attention, withdrawal can lead to serious injury or death.

Deaths from withdrawal are preventable, and jail administrators have a pressing responsibility to establish and implement withdrawal policy and protocols that will save lives and ensure legal compliance. This brief describes the scope of the challenge, provides an overview of constitutional rights and key legislation related to substance use withdrawal, and outlines steps for creating a comprehensive response to SUD.

When Kelly Coltrain was booked for unpaid traffic violations in 2017, she told jail staff that she was drug dependent and had a history of seizures. Her request to go to the hospital for help with withdrawal symptoms was denied. She was placed in a cell that required 30-minute checks, but these checks rarely occurred. For the next 3 days, she was observed (by video camera) vomiting, sleeping often, and eating little. On her third night in jail, she started convulsing; then, all movement ceased. For at least the next 4 hours, no deputies or medical staff came to the cell to determine why she was still. Kelly's family filed a wrongful death suit, which was settled in 2019 for $2 million plus 4 years of federal district court monitoring of the jail during implementation of new policies and procedures to ensure proper care of inmates at risk of withdrawal.[2]

Scope of the Challenge

Among sentenced individuals in jail, 63 percent have an SUD, compared to 5 percent of adults who are not incarcerated.[3] From 2000 to 2019, the number of local jail inmates who died from all causes increased 33 percent; the number who died from drug/alcohol intoxication during the same period increased 397 percent.[4] Among women incarcerated in local jails, the average annual mortality rate due to drug/alcohol intoxication was nearly twice that of their male counterparts.[5] The median length of stay in jail before death from alcohol or drug intoxication was just 1 day,[6] indicating that individuals on short stays, including those who are detained in pretrial status, are equally at risk.

It is not uncommon for individuals to experience substance withdrawal at the time of entry into jail, when access to their drug of choice is abruptly stopped. Estimates within specific regions vary widely, from 17 percent of people entering New York City jails being in acute opioid withdrawal[7] to a record 81 percent of people entering a Pennsylvania county jail needing detoxification services—half of them for opioid use disorders.[8]

* As noted in the Substance Abuse and Mental Health Services Administration's *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings* (2019), medically supported withdrawal (also referred to as medical detoxification) is "designed to alleviate acute physiological effects of opioids or other substances while minimizing withdrawal discomfort, cravings, and other symptoms."

This project was supported by Grant No. 2019-AR-BX-K061 to Advocates for Human Potential, Inc. awarded by the Bureau of Justice Assistance, a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. Advocates for Human Potential, Inc. was supported by the Addiction and Public Policy Initiative of the O'Neill Institute for National and Global Health Law at Georgetown University Law Center. This project was developed in partnership with the National Institute of Corrections, an agency within the Department of Justice's Federal Bureau of Prisons.

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Managing Substance Withdrawal in Jails: A Legal Brief | Bureau of Justice Assistance (ojp.gov)

- Screening
- Clinical assessment
- Onsite withdrawal management vs external transfer
- "Pathway to recovery"

U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Assistance

GUIDELINES FOR MANAGING SUBSTANCE WITHDRAWAL IN JAILS

A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals

June 2023

BJA
NIC
National Institute of Corrections

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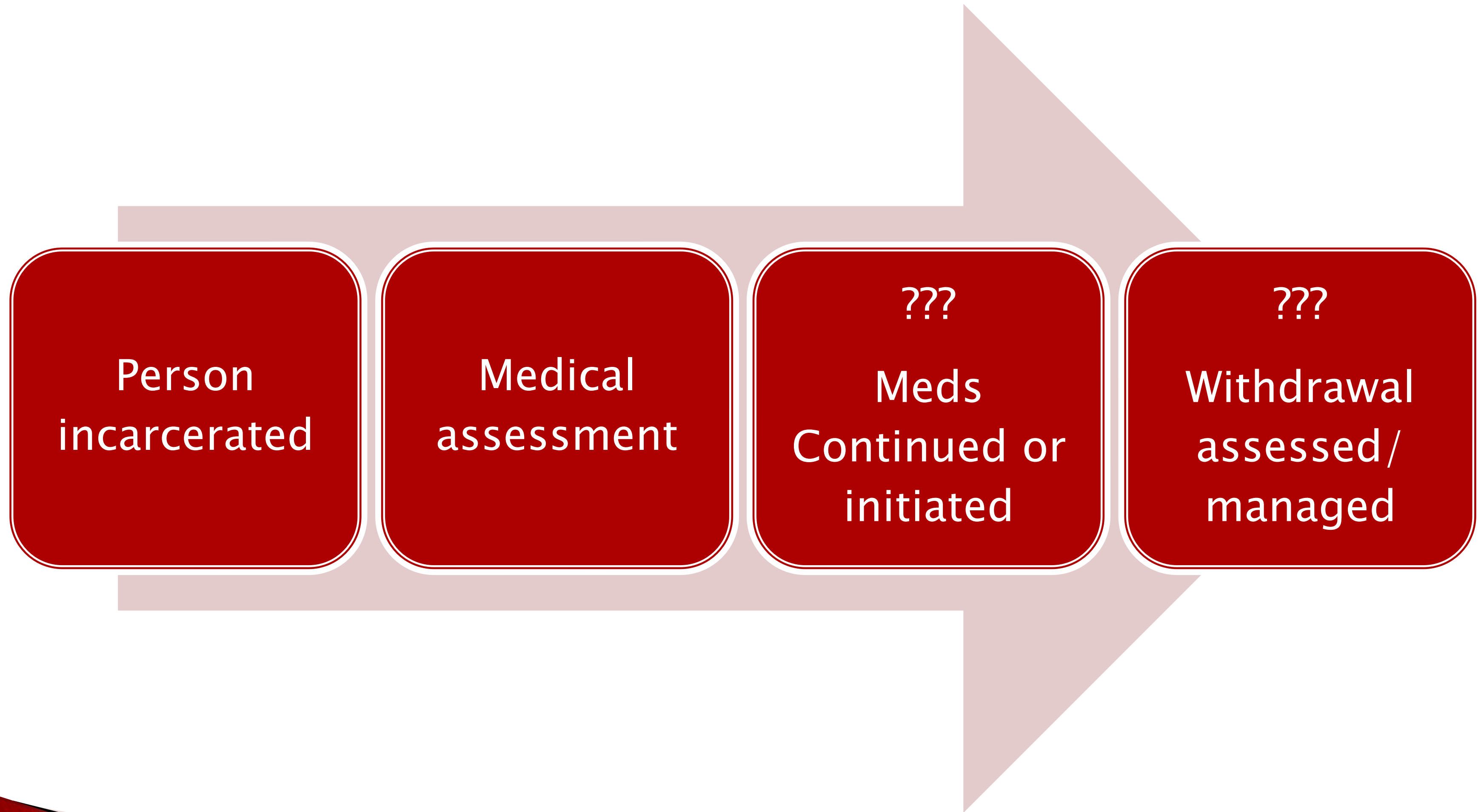
[GUIDELINES FOR MANAGING SUBSTANCE WITHDRAWAL IN JAILS (cossup.org)]

What Actually Happens During Incarceration



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Discussing Legal Involvement in Clinic

- Part of standard intake
  - Use non-stigmatizing language
- Provide rationale for why you are asking:
  - Support patient
    - Letters
    - Coordination of care
  - Understand available services and resources through court/probation/parole

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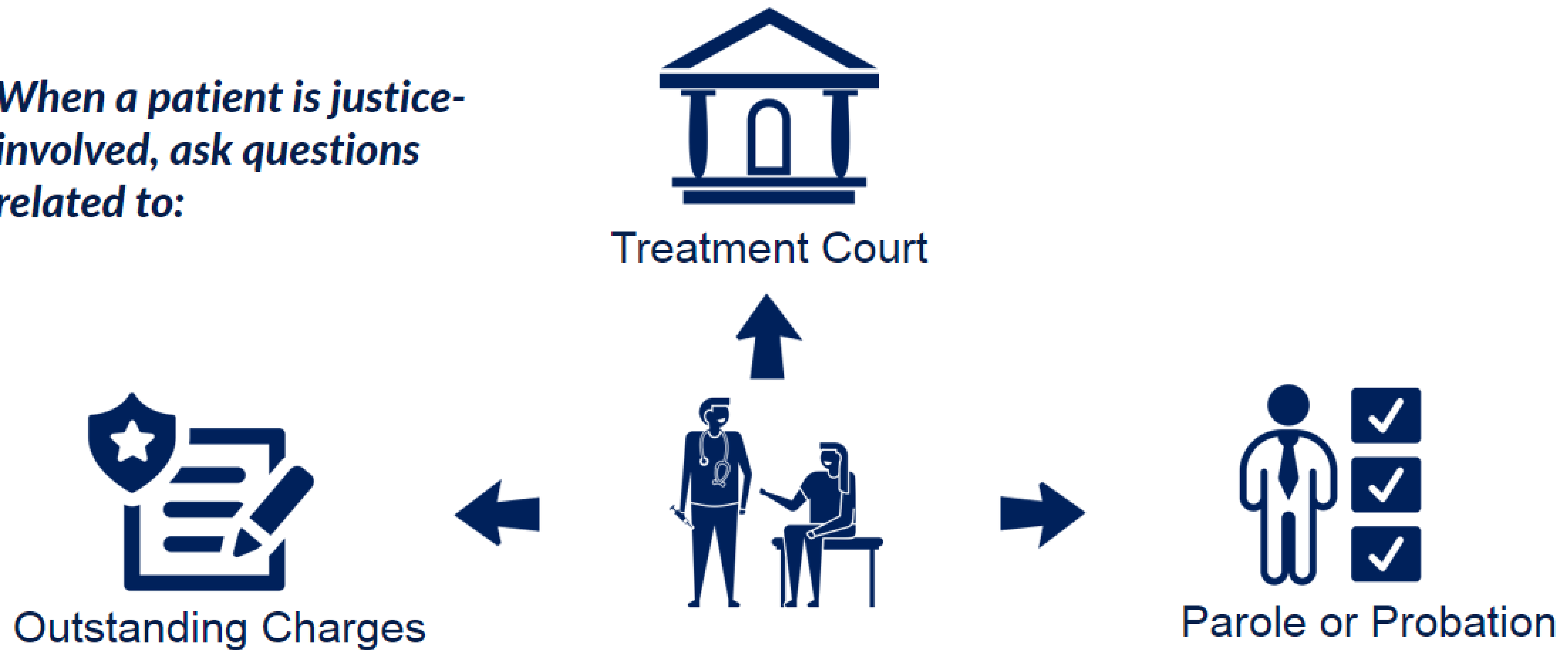
Discussing Legal Involvement



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Discussing Outstanding Charges

What is the anticipated outcome?

Which county?

If jail time is anticipated, when?

Does the jail allow MOUD?

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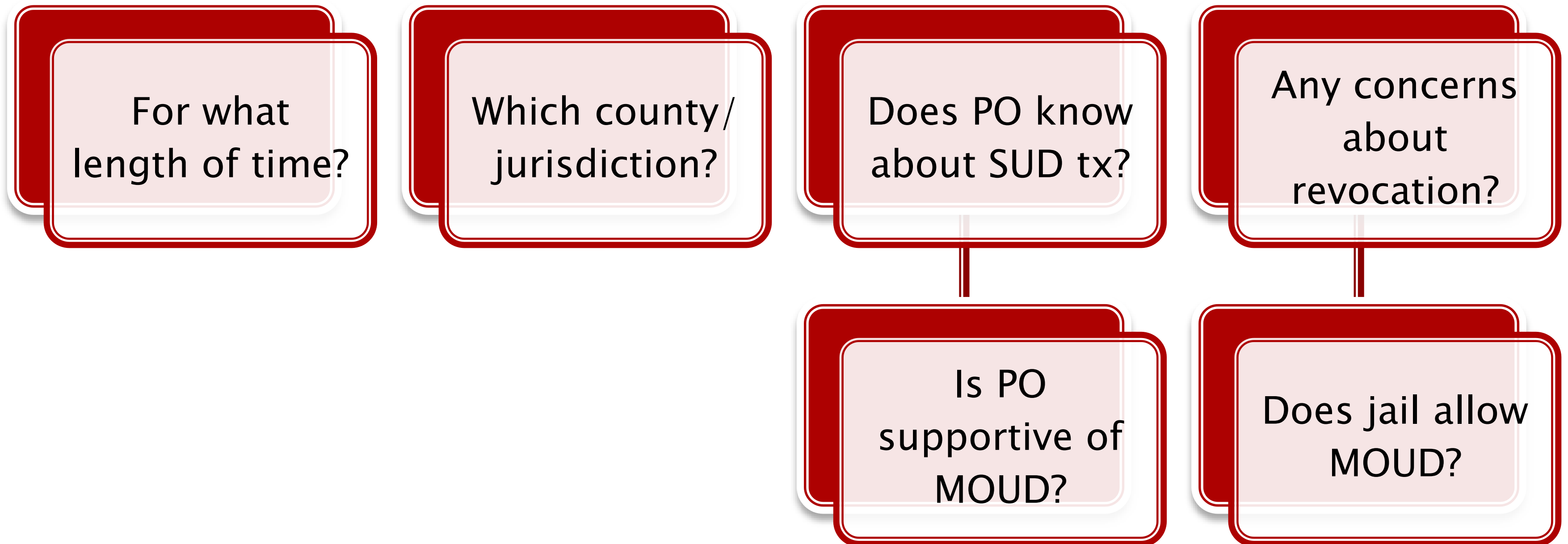
Discussing Parole and Probation



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Discussing Treatment Court

- Which County?
- Where in the treatment court phases?
- Does team know about MOUD?
  - Are they supportive?
- Any concerns about return to jail?
  - Does jail allow MOUD?

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Planning for Anticipated Jail Time

1. Which medications are allowed in jail (MOUD and psych)
2. Does patient need to bring own medications and coordinate with jail?
3. Send medical diagnoses and a medication list to jail (with signed ROI)
4. Discuss additional ROIs for care coordination while incarcerated

   (family, trusted person, etc)

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Planning for Anticipated Jail Time

*If MOUD is **not** allowed to be continued:*

- According to the DOJ, not allowing someone to continue prescribed MOUD while incarcerated is a violation of the ADA.
- Encourage the patient to report case to the Department of Justice (DOJ) or have patient sign release so you can submit on their behalf.

Source: Department of Justice (DOJ) https://www.ada.gov/opioid_guidance.pdf
https://civilrights.justice.gov/report/

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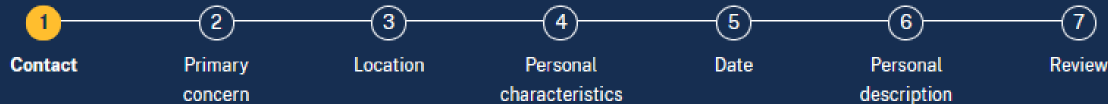
United States Department of Justice

Contact the Department of Justice to report a civil rights violation



If you believe you or someone else has experienced a civil rights violation, please tell us what happened.

Contact

You are not required to provide your name or contact information. If you want to remain anonymous, leave this section blank. If you choose to provide your contact information, we will only use it to respond to your submission.

Project ECHO University of Wisconsin

https://civilrights.justice.gov/report/

Discussing Release of Information

Ensure the patient understands what the release includes:

- Specific time periods
- Exactly which records

If a patient wants to revoke a release, it should be done <u>in writing</u>.

42 CFR 164.508(5) https://www.govinfo.gov/content/pkg/CFR-2018-title45-vol1/pdf/CFR-2018-title45-vol1-sec164-508.pdf

Photo purchased from istock

Case Example

- Existing patient on SL buprenorphine/naloxone who is on probation gets new charges – knows he will do jail time
- Clarified county and called the jail to ask about which meds he can continue while there.
- Jail does not allow buprenorphine; will allow SSRI but patient needs to bring medications when they present
- Patient anticipates it will be at least 6 months until he actually goes to jail

What next?

- Discuss transition to XR buprenorphine
- Discuss signing ROI for jail (will fax over med list and problem list when he goes)
- Discuss signing ROI for next of kin or trusted person whom they will speak with while incarcerated
- Plan for 90 day fill of SSRI immediately prior to presenting to jail
- Partner with next of kin for any needed ongoing refills
- Plan for return to care at time of release

What happened?

- Had enough time to give multiple XR buprenorphine injections (300mg) prior to incarceration
- ROI completed for jail and for patient's sister
- Patient took 90 days of meds (SSRI) at time of incarceration
  - When refills were due, sister called me and I would refill, she would pick up and take to jail
- Patient eventually got Huber release
  - Was able to come to clinic for continued XR buprenorphine injections
- Was already linked back to care at time of release to probation

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Conclusions

- Ask patients about legal involvement in standardized and non-stigmatizing way
- Work with patients to plan for anticipated jail/prison time:
  - Determine which medications are allowed
  - Make plans (transition to injectable formulation, send patient with medications as needed)
  - Make plans for coordination of care while incarcerated
  - Make plans for follow up at time of release
- Advocate for local jails to follow best practices
  - Share resources and as patients are willing report violations of ADA